BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	Case No. 800-2017-030024
RICHARD NEILL SAUER, M.D.	OAH No. 2018040456
Physician and Surgeon's Certificate No. A 29403	
Respondent.	

DECISION AFTER NON-ADOPTION

This matter was heard before Administrative Law Judge ("ALJ") Danette C. Brown, Office of Administrative Hearings (OAH), State of California, on January 28 to 30, 2019, in Sacramento, California.

Megan O'Carroll, Deputy Attorney General, represented complainant Kim Kirchmeyer, Executive Director of the Medical Board of California (Board).

Albert Garcia, Attorney at Law, represented respondent Richard Neill Sauer, M.D., who was periodically present at the hearing.

Evidence was received, the record was held open for submission of written closing briefs. On February 1, 2019, OAH received and marked complainant's closing brief as Exhibit 17. On February 19, 2019, OAH received and marked respondent's closing brief as Exhibit D. On February 22, 2019, OAH received and marked complainant's reply brief as Exhibit 18. The record closed and the matter was submitted for decision February 22, 2019.

On March 19, 2019 ALJ Brown issued her Proposed Decision. Panel B of the Medical Board of California ("Board") declined to adopt the Proposed Decision and on May 14, 2019 issued its Order of Non-Adoption of Proposed Decision and afforded the parties the opportunity for written argument. The Board having read and considered the administrative record and the written arguments submitted by the parties, and having heard oral argument, hereby renders its decision in this matter.

FACTUAL FINDINGS

1. On July 28, 1975, the Board issued respondent Physician and Surgeon's Certificate No. A 29403 (certificate). The certificate was current at all times relevant to this matter. It will expire on October 31, 2020, unless renewed or revoked.

2. On January 23, 2019, complainant, acting in her official capacity, signed and thereafter filed the First Amended Accusation against respondent. Complainant seeks to impose discipline on respondent's certificate, based on his alleged repeated acts of negligence in connection with his treatment of patient D.D.,[1] who sought treatment from respondent for tremors. Generally, complainant alleged that respondent departed from the standard of care by: (1) failing to perform an adequate initial neurological consultation; (2) failing to document the medical records with legible entries of vital signs, examination and significant changes or response to treatments; (3) failing to order appropriate tests and medical investigation of symptoms; (4) failing to appropriately prescribe medications; and (5) failing to effectively communicate with D.D. about D.D.'s condition, treatment plan, and prescriptions. Complainant also alleged that respondent failed to keep adequate and accurate medical records for services rendered to D.D.

3. Respondent timely filed a Notice of Defense, pursuant to Government Code section 11506. The matter was set for an evidentiary hearing before an Administrative Law Judge of the Office of Administrative Hearings, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500 et seq.

Respondent's Background

4. In 1974, respondent completed his medical degree at the University of Iowa, College of Medicine. Thereafter he completed an internship at United Hospitals in St. Paul Minnesota. In 1975, he was licensed by the Board. In 1978, respondent completed a three-year residency in neurology at the University of California, Davis (UC Davis). In 1981, he obtained his board certification by the American Academy of Neurology and Psychiatry.

5. In a prior disciplinary action entitled, "In the Matter of the Accusation against Richard Neill Sauer, M.D." before the Medical Board of California, OAH No. 2017040877, respondent's certificate was revoked, the revocation stayed, and respondent was placed on Board probation for five years, subject to terms and conditions. The Board adopted the administrative law judge's proposed decision, which became effective on May 18, 2018. The allegations in the case included respondent's repeated acts of negligence in his treatment of two patients for migraines, failing to document and take vital signs, and ordering an unnecessary EEG study.

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[1] The patient is identified by initials to protect the patient's privacy.

Board Investigation

6. On or about February 8, 2017, the Board received an online written complaint from D.D.'s caregiver, Meghan Maloney, who, at the time, was a recent registered nursing graduate. The complaint related to respondent's diagnosis and treatment of D.D.'s loss of motor skills, difficulty swallowing, difficulty speaking, and tremors. The complaint stated, in part:

> I went with [D.D] to see [respondent] and was absolutely sickened by his demeanor and lack of empathy or concern for [D.D.]. He had a pleasant smile but never asked [D.D.] any questions or bothered to look at [D.D.] when [D.D.] was speaking.
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> [D.D.'s] primary doctor told [D.D.] that she suspects MS[2] . . . Sadly, [respondent] laughed at [D.D.] saying no you don't have MS. But he didn't even ask her if things had changed or how she was since last visit!
>
> [¶] . . . [¶]
>
> He told [D.D.] the reason for [D.D.'s] new tremors was likely due to being in so much pain it was being expressed as a tremor. When I questioned his logic, asking for an explanation, he wasn't able to give me an answer that made sense and wrote a prescription for another medication without any info or explanation of how it would work or why he chose it.

7. On March 17, 2017, Michel Torres, a Special Investigator for the Department of Investigation, Health Quality Investigation Unit, was assigned to investigate the complaint. Investigator Torres issued an Investigation Report regarding his investigation of respondent. Investigator Torres testified at hearing. During the course of his investigation, Investigator Torres learned that Ms. Maloney had concerns about the care D.D. received from respondent on February 8, 2017, in that he did not address D.D.'s symptoms and prescribed D.D. medication that D.D. did not need. Ms. Maloney made attempts to contact respondent but did not receive a phone call back. Investigator Torres interviewed Ms. Maloney and D.D. He interviewed respondent and obtained his patient records for D.D.

8. On December 12, 2017, Investigator Torres sent a letter, draft report, a transcript of respondent's interview and the D.D.'s medical records to Board expert reviewer For Shing Lui, M.D., who is board-certified in Neurology. On December 18, 2017, Dr. Lui issued a report in which he opined that respondent's treatment of patient D.D. departed from the standard of care.

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[2] Multiple sclerosis.

Respondent's Treatment of Patient D.D.

9. D.D. is 48 years old. At the time D.D. was seen by respondent, D.D. was 46 years old. Prior to seeing respondent, D.D. had been treated regularly by Marina Kamyshin, Physician Assistant (PA), at the Sacramento Family Medical Clinic. D.D. had a complicated medical history of hypertension, chronic pain, fibromyalgia, depression, obesity, cholelithiasis[3], and hepatosplenomegaly[4]. D.D. had a history of seizures during childhood and was treated with phenobarbital until age 13. D.D.'s seizures reoccurred in 2007. The seizures were described in the medical records as "inconsistent" and "not stereotyped." D.D. had an inconsistent history of any impairment of consciousness. D.D. experienced intermittent body spasms with full awareness. D.D. was sent to the emergency department at Mercy San Juan Medical Center with one of these spells.

10. D.D. is a chronic cigarette smoker and used methamphetamine. In 2012, D.D. attempted suicide by taking Ativan and methamphetamine. D.D. is unemployed, and has a caregiver 30 hours per week. Prior to being seen by respondent, D.D.'s medications included Atenolol, Losartan, Oxybutynin, Gabapentin, Cymbalta, Ibuprofen, Norco (as needed), Comapazine (as needed), and Zofran (as needed).

11. D.D.'s primary care provider, PA Kamyshin, referred D.D. to respondent. Respondent first saw D.D. on November 17, 2016[5], with follow-up appointments on December 15, 2016, February 7, 2017, and March 6, 2017. Respondent provided a typewritten report to PA Kamyshin concerning his initial evaluation of D.D., describing that D.D. presented with bothersome head and upper extremity tremor starting in 2011. D.D. also had a spell of tonic-clonic[6] activity in October 2016, with probable loss of consciousness during the spell. Examination was normal except mild intention of tremor of D.D.'s upper extremities. Respondent's impression was the following:

a. This patient's tremor appears to be a benign essential tremor. The patient is moderately bothered with this now.

b. The patient's tonic-clonic spell may be a seizure or have another etiology.

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[3] Gallstones.

[4] Enlarged liver and spleen.

[5] The First Amended Accusation identified the first visit date as November 7, 2016. However, respondent's typewritten report indicates that the first visit took place on November 17, 2016, which was confirmed by respondent and complainant's expert at hearing.

[6] Grand-mal seizure.

Respondent recommended further evaluation with an electroencephalogram (EEG) and ultrasonography, also referred to as transcranial ultrasound. Respondent also prescribed Keppra 500 milligrams (mg) and Mysoline 50 mg twice a day.

12. On December 7, 2016, respondent performed the transcranial Doppler ultrasound and EEG tests on D.D. Respondent reported the results of both tests as normal.

13. On December 15, 2016[7], respondent saw D.D. for a follow-up appointment. Respondent's handwritten notes of this visit were illegible. Respondent provided a transcription of his notes to Investigator Torres, wherein D.D. complainted of "twitching." Respondent noted a history of childhood seizures, and noted a normal examination. Respondent's impression was that some of the reported symptoms were "pseudoseizures." He continued D.D. on Keppra 500 mg twice a day. The record is unclear whether respondent also continued D.D. on Mysoline at the same dose, however, in D.D.'s follow-up appointments, respondent continued D.D. on Keppra and Mysoline at the same doses.

14. D.D. returned to respondent for a follow-up appointment on February 7, 2017. Respondent's handwritten clinical notes were illegible. Respondent told Investigator Torres during his interview that D.D. complained of the same symptoms as in previous visits, and that the D.D. spoke in whispers with intermittent normal voice. D.D.'s speech pattern had been abnormal since 2007. D.D.'s examination was unremarkable. Respondent continued D.D. on Keppra and Mysoline at the same doses.

15. D.D. returned to respondent for a follow-up appointment on March 6, 2017. Respondent's handwritten clinical notes were illegible. Based on respondent's transcription of his notes and his interview with Investigator Torres, D.D. complained of seizures, with one that occurred the previous day. D.D. spoke with a lisp, which respondent noted had been present since age five. Respondent increased the Keppra dosage to 500 mg, two tablets, twice a day. Mysoline was continued at the same dose. Respondent scheduled a repeat EEG and a return visit in six weeks. The EEG was performed on March 13, 2017, and reported by respondent as normal. D.D. also had magnetic resonance imaging (MRI) performed on April 1, 2017, which was reported as "artefactual."[8] D.D. failed to show up to her appointments with respondent on April 17, 2017, and May 2, 2017. Ms. Maloney, who was with D.D. during her appointments with respondent, filed her complaint with the Board on February 8, 2018.

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[7] The First Amended Accusation indicates the follow-up visit took place on December 1, 2016. However, respondent's notes and complainant's expert confirmed that the follow-up visit occurred on December 15, 2016.

[8] "Artefactual" means referring to an inaccurate finding, deviation, or alteration of electronic readout or morphology due to some form of systemic error. (https://medical-dictionary.thefreedictionary.com/artefactual.)

Complainant's Expert

16. For Shing Lui, M.D., is Board-certified in neurology and the subspecialty of vascular neurology. Dr. Lui has been a Fellow of the American Academy of Neurology since 2017. In 1978, Dr. Lui graduated from the University of Hong Kong Medical School as the top graduate in his class. Following his residency in internal medicine, Dr. Lui went to England to become a Fellow in Clinical Neurology at the Regional Neurological Center. He returned to Hong Kong in 1984, as the medical officer at Queen Elizabeth Hospital, then worked in private practice as a neurologist and internist. Dr. Lui came to the United States, and in 1995, he became a resident in Neurology at UC Davis. He was Chief Resident at UC Davis in 1998. He thereafter served as a clinical professor at UC Davis from 1999 to 2014. He was Chief of Neurology Services at the Kaiser Permanente Medical Group in Sacramento and Roseville from 2004 to 2007.

Dr. Lui has served as a medical expert for the Board since September 2016. He currently serves as the Vice Chair of Clinical Sciences at California Northstate University College of Medicine.

17. Following a December 12, 2017 referral from Investigator Torres, Dr. Lui authored a report dated December 18, 2017, concerning his evaluation of respondent's conduct related to the treatment of D.D. In the report, Dr. Lui listed the documents he reviewed to reach his opinions and conclusions. Dr. Lui reviewed Investigator Torres's report, Ms. Maloney's complaint to the Board, the certified medical records of D.D., and a transcript and voice recording of respondent's interview with Investigator Torres. Dr. Lui testified at hearing consistent with the contents of his report. Dr. Lui opined that respondent's treatment of D.D. departed from the standard of care, which he defined as what a reasonable neurologist would do in a similar circumstance. Dr. Lui further explained that a simple departure from the standard of care means "any deviation," and an extreme departure from the standard of care means "reckless disregard or gross negligence."

INITIAL NEUROLOGY CONSULTATION

18. Dr. Lui opined that the standard of care for a neurologist's first consultation requires a detailed and comprehensive history of present illness, including relevant positives and negatives to help define the diagnosis and differential diagnoses. The elements of a complete history include: past medical history; medications; allergies; family history; social history; and review of systems. There should be at least a focused physical examination with vital signs documented. The assessment and plan should include a list of diagnoses or differential diagnoses with discussions about the more likely diagnoses followed by tests to help differentiate the diagnoses and recommend a treatment plan.

19. Dr. Lui reviewed respondent's typewritten report dated November 17, 2016, addressed to PA Kamyshin. Respondent's report stated that the initial consultation with D.D. occurred on November 17, 2016. Respondent listed two symptoms that D.D. complained of without providing details. Dr. Lui found no past medical history, history of allergies, an

inadequate social history lacking alcohol and drug use, and no review of systems. There were no vital signs noted in D.D.'s examination except a blood pressure reading. Dr. Lui opined that respondent's description of D.D.'s history, and respondent's physical examination were "grossly inadequate." Moreover, respondent did not obtain any details about D.D.'s childhood seizures and treatment, yet diagnosed D.D with possible seizures and benign essential tremor. Dr. Lui concluded that respondent's first visit with D.D. was a simple departure from the standard of care.

FAILURE TO DOCUMENT MEDICAL RECORD WITH LEGIBLE ENTRIES OF VITAL SIGNS, EXAMINATION, AND SIGNIFICANT CHANGES

20. Dr. Lui opined that the standard of care for any physician is to take a complete or focused history and physical examination with truthful, accurate, and legible documentation in the patient's chart. Vital signs are an important part of the physical examination.

21. Dr. Lui reviewed respondent's notes in D.D.'s chart. The notes were handwritten, extremely brief, and illegible. Dr. Lui opined that respondent's documentation lacked any description of significant changes in D.D.'s existing problems and response to treatment. No vital signs were documented in any return visit after the initial consultation. Neither Dr. Lui nor any other physician would be able to rely on respondent's handwritten notes because they were illegible. Dr. Lui concluded that respondent's chart documentation in D.D.'s medical record was a simple departure from the standard of care.

FAILURE TO ORDER APPROPRIATE TESTS AND MEDICAL INVESTIGATION OF SYMPTOMS

22. Dr. Lui opined that the standard of care in clinical practice by any physician for requesting or ordering tests or investigations is to define the indication of the test as well as cost consideration under the circumstances.

23. Dr. Lui further opined that D.D. presented with "clinical seizures or pseudoseizures" and tremor, and that it would be important for respondent to obtain a history from D.D. to get details of the "spells" and the factors that may aggravate or alleviate D.D.'s symptoms of tremor. Logical lab studies would include a complete metabolic panel, thyroid function, EEG, and MRI. A metabolic panel would be informative due to D.D.'s enlarged liver and spleen. Thyroid function studies would also be important because the thyroid could be the cause of D.D.'s tremor. Respondent ordered an EEG, and he determined that the results were normal. Respondent did not order or obtain recent results of the thyroid or metabolic panel tests.

24. Dr. Lui testified that a transcranial Doppler test is indicated for the following reasons: (1) sickle cell disease where a follow-up is needed to determine the patient's need

for a blood transfusion; (2) subarachnoid hemorrhage vasospasm[9]; and (3) determining velocity of blood flow in the intracranial vessels. There was nothing in D.D.'s history to indicate a stroke. There was "absolutely NO indication for the transcranial Doppler testing" for D.D. (Capital letters in original.) Dr. Lui concluded that the transcranial Doppler test requested by respondent was a simple departure from the standard of care.

FAILURE TO APPROPRIATELY PRESCRIBE MEDICATIONS

25. Dr. Lui opined that the standard of care in prescribing any medication by a physician requires the physician to know the patient's past medical history, including renal and liver functions. Those functions provide information on whether any dose adjustment is necessary. In addition, allergy and social history, especially use of alcohol and street drugs, may affect the choice of medications prescribed to the patient. Obtaining a detailed history of the patient's medications is especially important because of drug interactions. It is only after obtaining the patient's histories that the best medication specific to the patient may then be prescribed.

26. Dr. Lui determined that respondent obtained very limited medical history of D.D. Respondent also needed to obtain vital signs. D.D. used methamphetamine, which could have increased her blood pressure and heart rate. D.D. was taking Gabapentin for seizures and tremors. Gabapentin may increase body weight. Given that D.D. was morbidly obese, considered as having a body max index (BMI) over 40, respondent would have needed to continue discussing with D.D. whether to discontinue Gabapentin. In a morbidly obese individual such as D.D., continued use of Gabapentin would have affected D.D.'s everyday activities, and contributed to sleep apnea, right side heart failure, metabolic syndrome, and liver and spleen enlargement.

27. D.D. was also taking Mysoline, known as a "beta-blocker," which may have helped her tremors. Instead of adding a new medication with different side effects, Dr. Lui opined that respondent should have considered adjusting the dose of her existing medications before switching to a new medication. He stated, "when we start a patient on a new medication, we need to explain very clearly the reason for the use, side effects, and it relevance on the effects of daily living."

Respondent knew that D.D. was taking Cymbalta[10] for fibromyalgia. Despite being contraindicated for depression, respondent prescribed Keppra for D.D.'s seizures, which was troubling for Dr. Lui, and "would not have been a good choice in the presence of depression." Dr. Lui opined that 15 percent of patients taking Keppra will experience the

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[9] Bleeding in the space between the brain and the tissue covering the brain. (https://emedicine.medscape.com/article/1164341-overview.)

[10] Duloxetine is the generic name for Cymbalta. It is used to treat depression and anxiety. In addition, duloxetine is used to help relieve nerve pain (peripheral neuropathy) in people with fibromyalgia and other medical conditions. (https://www.webmd.com/drugs/2/drug-91491/cymbalta-oral/details.)

side effect of depression. Dr. Lui further opined that prescribing Keppra "was especially risky" given that D.D. attempted suicide in 2012. Moreover, respondent increased the dose of Keppra when he suspected more pseudoseizures. Dr. Lui conceded that Keppra is commonly used, and he gave respondent "the benefit of the doubt" in this regard. However, given D.D.'s depression and suicidal history, Dr. Lui concluded that respondent's choice of prescription medication, Keppra, was a simple departure from the standard of care.

FAILURE TO EFFECTIVELY COMMUNICATE WITH PATIENT D.D.

28. Dr. Lui opined that the standard of care for a physician to communicate with a patient "is to always try to communicate well with the patient and show empathy." Diagnoses, treatment plans, medications prescribed and their indications, side effects, and drug interactions, must be clearly conveyed to the patient.

29. Dr. Lui found no documentation in D.D.'s chart that respondent explained to D.D. and Ms. Maloney any details about D.D.'s diagnoses, or the risks and benefits of medication prescribed to D.D. Dr. Lui opined that neither D.D. nor Ms. Maloney would have filled the Keppra prescription had they known of Keppra's side effects of depression, given D.D.'s history. Dr. Lui noted that inadequate communication and lack of empathy by respondent was also the main complaint filed by Ms. Maloney. D.D. called respondent the day after her March 13, 2017 EEG appointment, seeking clarification on how often she was to take a particular prescribed medication, demonstrating respondent's failure to effectively communicate with D.D. on how to take the medication. Dr. Lui did not see from respondent's documentation "any real communication." Dr. Lui testified that "MS was not discussed. I would expect respondent would document that MS was brought up by the provider and referring PA, and that respondent would document that [MS] was not likely." Dr. Lui concluded that respondent's failure to effectively communicate was a simple departure from the standard of care.

Respondent's Testimony

30. Respondent acknowledged that his handwritten notes regarding D.D. were difficult to read. However, he claimed that he was able read his own notes, as was his staff. Respondent later conceded, "there is always room for improvement" concerning his medical record documentation. When asked about a note written by one of his staff, which was also difficult to read, respondent snidely remarked that the Board should "go after her too" for poor penmanship. Respondent has a transcriber, and he will "type more and write less" in the future. He referred to his handwritten notes as "secret handwriting" which enables him at the end of the day to dictate a specific note to the referring doctor. Respondent described himself as the "pawn of the referring doctor," meaning that the referring doctor is less concerned with his notes than the ongoing treatment plan for the patient. He asserted that referring physicians have been happy with his typewritten reports.

31. Respondent also asserted that he performs a thorough and focused examination of his patients, which includes history taking. He relies on the primary care provider to

provide the vital signs. Respondent did not take D.D.'s temperature or weight, explaining that this information was not pertinent to the referral. He "rarely checks" the blood pressure of patients. He noted D.D.'s blood pressure during his initial consultation, but he did not know who took D.D.'s blood pressure, stating that either the patient told him, it was on another record, or his staff took D.D.'s blood pressure. He believed it a "ludicrous suggestion" to document oxygen saturation,[11] which should be done by a pulmonologist, not him. In his experience, no one has "jotted that down" as a vital sign. He asserted that every patient that comes to his practice has already had their vital signs taken, and therefore the vital signs need not be a part of his documentation. He only focuses on what is asked of him. Respondent claimed that he discussed D.D.'s vital signs with PA Kamyshin, but there is no documentation of that discussion.

32. Respondent has performed transcranial Doppler tests since the technology was invented. He performs four to six tests per month. He stated that the test is non-invasive, not painful, and is a tenth of the cost of other technologies. The transcranial Doppler is helpful in providing information about vasospasms, blood flow, and seizure activity. Respondent ordered a transcranial Doppler test for D.D. because D.D.'s "tremor history was confusing," D.D. was a smoker that potentially put her at risk for stroke, and the test would have provided information on blood vessel abnormalities, blood flow problems, stroke detection, and vascular supply to neurons, known as neurovascular coupling.

33. Respondent did not order a metabolic panel or thyroid function test for D.D., but would have done so in a "brand new patient with no testing or blood workup." If D.D. presented with a suspicious condition of a metabolic process or thyroid abnormality, or if D.D. had clinical signs of low or high thyroid hormone levels, he would have ordered the tests.

34. Respondent has prescribed Keppra to "thousands of people." It is an anti-convulsant used in the treatment of seizures. Respondent chose Keppra for D.D. for two reasons: (1) Keppra prevented D.D. from dying from a seizure; and (2) Keppra would "stop or diminish the spells [D.D.] was describing." Respondent also chose Keppra for D.D. because it would not interact with the Gabapentin D.D. was taking. In his experience, respondent believed that Keppra and Gabapentin were a good combination. He also chose Keppra because over 50 percent of people actually need more than one anti-convulsant. Respondent asserted that very few, out of the thousands of his patients, have had a side effect from Keppra, and none have experienced depression or suicidal ideation. Respondent had no documentation that he communicated the negative effects of Keppra to D.D., and admitted that he did not inquire about D.D.'s condition after he prescribed Keppra.

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[11] Oxygen saturation is typically measured using a pulse oximeter. The patient's finger is inserted into spring-loaded clip which is attached to a sensor that provides a digital readout of the patient's oxygen saturation level. (https://www.healthline.com/health/pulse-oximetry.)

35. Respondent did not address his lack of communication with D.D. about D.D.'s condition, treatment plan, and prescriptions. Respondent testified that D.D. stopped seeing him because there was a "personality conflict" between himself and Ms. Maloney.

Discussion of Allegations

INITIAL NEUROLOGY CONSULTATION

36. Complainant alleged that respondent failed to perform an adequate initial neurological consultation on D.D., including failing to obtain detailed symptoms, perform a history and a physical, obtain significant social, allergy and medical history, and history of childhood seizures to reach a proper diagnosis and treatment plan. Complainant alleged that respondent's conduct constituted a repeated act of negligence, failure to maintain adequate and accurate records and general unprofessional conduct.

37. Dr. Lui persuasively opined that the standard of care requires that the treating neurologist's first consultation requires documentation of a detailed and comprehensive patient history, along with a focused physical examination with vital signs documented. This information is necessary to establish a list of diagnoses or differential diagnoses and a treatment plan. Dr. Lui opined that it is a simple departure from the standard of care to fail to document the patient's history and physical examination. Respondent's documentation in this regard was "grossly inadequate."

38. Respondent believed that he performed a thorough and focused examination, and provided an adequate history during his initial neurological consultation with D.D. Describing himself as the "pawn of the referring doctor," respondent asserted that he relies on the primary caregiver to obtain all of the detailed information that Dr. Lui set forth as the standard of care. Respondent provided no conflicting expert opinion on the standard of care.

39. The evidence established that respondent failed to document detailed symptoms, a thorough history and physical examination with vital signs for D.D. Respondent's assertion that referring physicians are happy with his reports is irrelevant.

40. Complainant established by clear and convincing evidence that respondent failed to perform an adequate initial neurological consultation on D.D. His conduct constituted a simple departure from the standard of care, failure to maintain adequate and accurate records and general unprofessional conduct.

LEGIBLE RECORDS

41. Complainant alleged that respondent failed to document the medical record adequately with legible records of vital signs, examination, and significant changes or response to treatments. Complainant further alleged that respondent's conduct constituted repeated acts of negligence, failure to maintain adequate and accurate records, and general unprofessional conduct.

42. Dr. Lui persuasively opined that the standard of care for charting is to legibly and accurately document the relevant medical information, including the vital signs of the patient. Respondent provided no conflicting expert testimony on the standard of care.

43. Respondent acknowledged his illegible notes regarding D.D. He explained that he and his staff could understand his writing, which he intended to transcribe later. However, even when transcribed, the content of the records was lacking in vital signs, and information concerning symptoms and response to treatment.

44. Complainant established by clear and convincing evidence that respondent failed to legibly and accurately document relevant medical information, including vital signs of D.D. His conduct constituted a simple departure from the standard of care, failure to maintain adequate and accurate records and general unprofessional conduct.

ORDERING APPROPRIATE TESTS AND MEDICAL INVESTIGATION OF SYMPTOMS

45. Complainant alleged that respondent failed to order appropriate tests and medical investigation of symptoms, by ordering unnecessary tests, such as the transcranial Doppler test, and failing to obtain necessary tests such as a metabolic panel and thyroid function tests. Complainant alleged that respondent's failures constituted repeated acts of negligence, failure to maintain adequate and accurate medical records, and general unprofessional conduct.

46. Dr. Lui persuasively opined that the standard of care in ordering tests or investigations is to define the indication, and to consider the cost. Dr. Lui further persuasively opined that there was no indication for ordering the transcranial Doppler test for D.D. Respondent provided no conflicting expert opinion on the standard of care. Respondent's testimony that he ordered the transcranial Doppler test because it would have provided information on stroke detection or blood vessel abnormalities was less persuasive, because respondent did not document any differential diagnoses that would have justified the test. Dr. Lui is Board-certified in neurology and in the subspecialty of vascular neurology, which specifically addresses blood flow in the brain. His opinion with respect to respondent unnecessarily ordering the transcranial Doppler test for D.D. is given greater weight. Dr. Lui did not find any departures from the standard of care with respect to respondent failing to obtain necessary tests such as the metabolic panel and thyroid function tests.

47. The evidence did not establish that respondent violated the standard of care by failing to obtain necessary tests such as the metabolic panel and thyroid function tests. Complainant established by clear and convincing evidence that respondent's conduct in ordering the transcranial Doppler test, without medical indications, constituted a simple departure from the standard of care, failure to maintain adequate and accurate records and general unprofessional conduct.

PRESCRIBING APPROPRIATE MEDICATIONS

48. Complainant alleged that respondent failed to appropriately prescribe medications, including prescribing Keppra in the presence of psychiatric and suicide history, and adding new medications without reference to existing prescriptions. Complainant alleged that respondent's conduct constituted a repeated act of negligence, failure to maintain adequate and accurate records and general unprofessional conduct.

49. Dr. Lui persuasively opined that the standard of care in prescribing any medication requires the physician to know the patient's past medical history, including renal and liver functions, as that information may require dosage adjustments. The standard of care also requires the physician to obtain a detailed history of the patient's medications as there may be drug interactions. Respondent provided no conflicting expert testimony on the standard of care.

50. Respondent's prescribing of Keppra to D.D. is the most serious issue in this case. Despite respondent's testimony that he prescribes Keppra to "thousands," and none of his patients have experienced depression or suicidal ideation, he provided no appropriate consideration of D.D.'s past history. If he did, it was not documented. The purpose of obtaining and considering the patient's history is to limit the risk of potential drug interactions and side effects. Respondent did not inquire about D.D.'s condition after the last time he saw her, and would have no way of knowing whether D.D. experienced any negative effects while taking Keppra.

51. The evidence established that respondent prescribed Keppra to a D.D., a patient with a history of depression and suicide. Complainant established by clear and convincing evidence that respondent's choice of Keppra was a simple departure from the standard of care, failure to maintain adequate and accurate medical records and general unprofessional conduct.

EFFECTIVE COMMUNICATION WITH PATIENT D.D.

52. Complainant alleged that respondent failed to communicate with D.D. about D.D.'s condition, treatment plan, and prescriptions. Complainant alleged that respondent's conduct constituted a repeated act of negligence, failure to maintain adequate and accurate medical records and general unprofessional conduct.

53. Dr. Lui persuasively opined that the standard of care in effectively communicating with a patient is to show empathy, and to clearly convey to the patient diagnoses, treatment plans, prescribed medications and their indications, side effects and drug interactions. Respondent provided no conflicting expert testimony on the standard of care.

54. Respondent did not acknowledge that he failed to effectively communicate with D.D. regarding her treatment, or that he lacked empathy. He defended his illegible

handwriting by asserting that he and his staff could read his notes, and referred to his notes as "secret handwriting." However, any reviewing doctor or D.D. would not be able to read or understand such notes, particularly if there are no transcribed notes in the patient's medical record. He did not convey to D.D. the risks to taking Keppra. He did not follow up with D.D. to inquire as to her condition when she stopped seeing him. He appeared defensive at hearing in having to account for his medical decision-making. Respondent provided no credible or persuasive testimony to demonstrate that he met the standard of care.

55. Complainant established by clear and convincing evidence that respondent's failure to communicate with D.D. about D.D.'s condition, treatment plan, and prescriptions, was a simple departure from the standard of care, a failure to maintain adequate and accurate medical records and general unprofessional conduct.

Rehabilitation Evidence

56. Respondent submitted five character reference letters which were received in evidence and considered to the extent permitted by Government Code section 11513, subdivision (d).[12]

a. Ingeborg Henderson, Ph.D., wrote in an email sent to respondent on January 9, 2019, that she has been treated by respondent since 2007 for chronic pain. Respondent suggested a course of treatment that restored Ms. Henderson's quality of life. Ms. Henderson was "profoundly impressed" with respondent's care, as well as respondent's willingness to "always listen" to Ms. Henderson's concerns, and to answer all of her questions. Ms. Henderson described respondent as a credit to his profession.

b. Sayed Hussain, M.D., wrote in his signed letter of January 7, 2019, that he has known respondent for decades, has referred patients "back and forth" over the years, and characterized respondent as an excellent physician. Dr. Hussain is aware of the Board's allegations in this case. Dr. Hussain's opinion is that respondent is "an honest, caring and competent physician, and certainly very professional." The allegations against respondent do not alter Dr. Hussain's opinion of respondent.

c. Raymond Mikelionis, M.D., wrote in his undated, signed letter, that he has known respondent for 40 years, and has worked with respondent in hospitals and a clinic. Dr. Mikelionis described

[12] Government Code section 11513, subdivision (d), provides, in pertinent part, that "[h]earsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions."

respondent as a "mainstay" at the local hospital who has "excellent results" as a general neurologist. Dr. Mikelionis especially appreciates respondent's "expertise in treating seizures." Dr. Mikelionis aware of the Board's allegations in this case, but his opinion of respondent as "very professional, honest, caring and competent" has not changed.

d. Algerd Mostavicius wrote in his signed letter of January 7, 2019, that he was a licensed physician in California from 1967 to 2017. He voluntarily surrendered his license (no payment of fees) and was in good standing with the Board. Mr. Mostavicius's wife, Barbara, was also an M.D. who surrendered her license in 2017 due to Alzheimer's Disease. Both are being treated by respondent. Both are aware of the Board's allegations, and are of the opinion that respondent is an "honest, well-trained, caring and very competent physician."

e. David S. Gould wrote in his signed and dated letter of January 7, 2019, that he has known respondent for many years, and "his care is of the highest standard." Mr. Gould is aware of the Board's allegations, "which in part includes an argument over which seizure medicine ought to be used." Despite the Board's allegations, Mr. Gould's opinion of respondent is not altered. He described respondent as an "honest, caring and competent physician, and certainly very professional."

57. The authors of the character reference letters were either physicians or respondent's patients. Mr. Gould is a good friend. Most of the authors had knowledge of the Board's allegations, but their opinion of respondent as a competent and compassionate medical professional did not change. Despite their knowledge of the Board's allegations, none of the authors provided any insight into respondent's efforts at rehabilitation despite the charges. (See, *Seide v. Committee of Bar Examiners of the State Bar of California* (1989) 49 Cal.3d 933, 940 ["If the character witnesses were not aware of the extent and seriousness of the petitioner's criminal activities, their evaluations of his character carry less weight."].) While there are no criminal activities at issue in this case, respondent's failure to adequately document D.D.'s symptoms, treatment, medical history, medications history, social history, and his failure to effectively communicate D.D.'s condition, treatment plan and prescriptions, were not addressed by any of the authors. Because the authors do not discuss knowledge of respondent's conduct, they are of limited value in assessing rehabilitation.

Appropriate Discipline

58. Complainant established by clear and convincing evidence the allegations contained in the First Amended Accusation. Additionally, complainant established that respondent engaged in multiple simple departures from the standard of care, including failing

to conduct an adequate initial consultation, documenting D.D.'s medical record with illegible notes, ordering a transcranial Doppler test without indication, prescribing inappropriate medication for the D.D., and failing to effectively communicate with D.D.

59. Most concerning is respondent's failure to acknowledge the serious nature of his multiple failures in treating D.D. He failed to maintain adequate and accurate records. His handwritten notes were illegible. He failed to document detailed information on D.D.'s medical history in order to reach a proper diagnosis and treatment plan. He did not convey medication risks.

60. Respondent failed to understand the seriousness of his illegible handwritten notes. A member of his staff also had poor handwriting which was difficult to read, and respondent snidely remarked that the Board should "go after her too" for poor penmanship. Respondent's hubris raises serious questions about his ability to examine his own professional conduct, take ownership of his actions, improve his practices as a medical practitioner, be open to accept challenges or suggestions by other medical practitioners, and demonstrate compassion towards patients. Respondent's preference of his own medical judgment over that of others poses a danger to his patients. At hearing, he demonstrated sarcasm and lack of respect for the discipline process, and the important role that the Board holds in protecting the public.

61. Respondent has been licensed to practice medicine in California since 1975. The Board imposed discipline in a prior Medical Board Case, OAH No. 2017040877. The allegations in the prior Board case involved, in part, respondent's treatment for migraines using Botox, his failure to document and take vital signs, and ordering of an unnecessary EEG test. Due to the severity of respondent's conduct and violations in that case, the Board needed assurances that respondent is safe to practice. The Board's Disciplinary Guidelines were considered, and discipline was imposed without deviation from the guidelines. The Board imposed a five-year disciplinary term, and required practice monitoring and a medical record keeping and ethics course, and a no solo practice term.

62. Here, D.D. was being treated for tremors and seizure, and the allegations highlighted the deficiencies in respondent's overall care and treatment, not just a specific subspecialty of neurology. This case implicated a much larger question of respondent's general fitness to practice. The protection of the public is the Board's highest priority. In determining appropriate disciplinary action and in exercising disciplinary authority the Board shall, whenever possible, "take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence." (Bus. & Prof. Code, § 2229, subd. (b).)

63. The Board's Disciplinary Guidelines provide the recommended minimum and maximum penalties for Business and Professions Code violations. For violation of Business and Professions Code sections 2234 (general unprofessional conduct), 2234, subdivision (c), (repeated negligent acts), and 2266 (failure to maintain adequate records), the minimum

penalty[13] is stayed revocation and five years of probation with conditions designed to protect the public. The maximum penalty is revocation. There is no basis here to deviate from the Disciplinary Guidelines.

64. Based on the totality of the evidence, the public protection would be served by imposing a five-year term of probation, with terms and conditions designed to protect the public. The five-year term of probation shall run concurrently with respondent's five-year term of probation in OAH Case No. 2017040877. Consistent with the conditions of probation in that case, respondent is prohibited from engaging in a solo practice and is required to obtain a practice monitor who will ensure that his practices are within the standards of practice of medicine. He is directed to complete a professionalism program and medical record keeping course to ensure that he understands his ethical obligations and his duty to maintain accurate and adequate records. Lastly, an additional term of probation, not required in his previous Medical Board case, will be required: Respondent shall complete a Clinical Competence Assessment Program as a condition precedent to his continuing practice. Completion of the assessment program will give the Board adequate assurances that the issues raised in the present case have been addressed, respondent's general fitness to practice is sound, and public protection is served.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

Burden and Standard of Proof

2. Complainant has the burden of proving each of the grounds for discipline alleged in the Accusation, and must do so by clear and convincing evidence. (See, *Ettinger v. Board of* Medical *Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence is evidence that leaves no substantial doubt and is sufficiently strong to command the unhesitating assent of every reasonable mind. (See, *In re Marriage of Weaver* (1990) 224 Cal.App.3d 478.)

Applicable Law

3. Business and Professions Code section 2227 provides in pertinent part that a licensee that has been found "guilty" of violations of the Medical Practices Act, shall:

(1) Have his or her license revoked upon order of the board.

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[13] The Board's Guidelines note that "in cases charging repeated negligent acts with one patient, a public reprimand may, in appropriate circumstances, be ordered."

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

4. Business and Professions Code section 2234 provides that the Board shall take action against any licensee found to have engaged in unprofessional conduct, which includes but is not limited to the following:

[¶] . . . [¶]

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1) including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

5. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care applicable in a medical professional must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal. App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.) The courts have defined gross negligence as

"the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052. Simple negligence is merely a departure from the standard of care.

6. Business and Professions Code section 2266 provides that failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

Causes for Discipline

7. Complainant established by clear and convincing evidence that respondent's treatment of D.D. constituted repeated acts of negligence, as set forth in Factual Findings 18 through 29, and 36 through 55. Therefore, cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c).

8. Complainant established by clear and convincing evidence that respondent failed to maintain adequate and accurate records related to his treatment of D.D. as set forth in Factual Findings 18 through 29, and 36 through 55. Therefore, cause exists to impose discipline on respondent's certificate pursuant to Business and Professions Code sections 2227 and 2234, as defined by section 2266.

Conclusion

9. The objective of an administrative proceeding relating to licensing is to protect the public. Such proceedings are not for the primary purpose of punishment. (See *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) When all the evidence is considered, respondent's certificate should be placed on probation for a period of five years, with appropriate terms and conditions set forth below, to protect the public. Respondent's five-year probation in this case shall run concurrent with his five-year probation imposed in a prior Medical Board case, OAH No. 2017040877.

ORDER

Physician's and Surgeon's Certificate A 29403 issued to respondent Richard Neill Sauer M.D. is REVOKED, pursuant to Legal Conclusions 7 and 8, but the revocation is STAYED, and respondent is placed on probation for five years, upon the following terms and conditions listed below. The five-year probationary period shall run concurrently with the five-year probationary period currently in effect pursuant to OAH No. 2017040877.

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval of

educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours are in satisfaction of this condition.

2. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. Monitoring – Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine and whether respondent is

practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

5. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the respondent's practice setting changes and the respondent is no longer practicing in a setting in compliance with this Decision, the respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

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6. Notification

Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice: Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years. Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

13. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

14. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

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17. Clinical Competence Assessment Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusations(s), and any other information that the Board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of three and no more than five days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendations(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

Respondent shall not practice medicine until respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

This Decision shall become effective at 5:00 p.m. on **October 3, 2019**.

IT IS SO ORDERED **September 3, 2019.**

Kristina D. Lawson, J.D., Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	)	
Richard Neill Sauer, M.D.	)	Case No.: 800-2017-030024
Physician's and Surgeon's Certificate No. A 29403	)	OAH No.: 2018040456
Respondent	)	

ORDER OF NON-ADOPTION OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** A panel of the Medical Board of California (Board) will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit directed at whether the level of discipline ordered is sufficient to protect the public. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Diamond Court Reporters, 1107 Second Street, Ste. 200, Sacramento, California 95814. The telephone number is 916-498-9288.

To order a copy of the exhibits, please submit a written request to this Board.

In addition, oral argument will only be scheduled if a party files a request for oral argument with the Board within 20 days from the date of this notice. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel. The Board directs the parties' attention to Title 16 of the California Code of Regulations, sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written argument.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831
(916) 263-2624
Attention: Sara Pasion

Date: May 14, 2019

Kristina D. Lawson, J.D., Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: RICHARD NEILL SAUER, M.D. Physician and Surgeon's Certificate No. A 29403 Respondent.	Case No. 800-2017-030024 OAH No. 2018040456

PROPOSED DECISION

This matter was heard before Administrative Law Judge Danette C. Brown, Office of Administrative Hearings (OAH), State of California, on January 28 to 30, 2019, in Sacramento, California.

Megan O'Carroll, Deputy Attorney General, represented complainant Kim Kirchmeyer, Executive Director of the Medical Board of California (Board).

Albert Garcia, Attorney at Law, represented respondent Richard Neill Sauer, M.D., who was periodically present at the hearing.

Evidence was received, the record was held open for submission of written closing briefs. On February 1, 2019, OAH received and marked complainant's closing brief as Exhibit 17. On February 19, 2019, OAH received and marked respondent's closing brief as Exhibit D. On February 22, 2019, OAH received and marked complainant's reply brief as Exhibit 18. The record closed and the matter was submitted for decision February 22, 2019.

FACTUAL FINDINGS

1. On July 28, 1975, the Board issued respondent Physician and Surgeon's Certificate No. A 29403 (certificate). The certificate was current at all times relevant to this matter. It will expire on October 31, 2020, unless renewed or revoked.

2. On January 23, 2019, complainant, acting in her official capacity, signed and thereafter filed the First Amended Accusation against respondent. Complainant seeks to impose discipline on respondent's certificate, based on his alleged repeated acts of negligence in connection with his treatment of patient D.D.,[1] who sought treatment from respondent for tremors. Generally, complainant alleged that respondent departed from the standard of care by: (1) failing to perform an adequate initial neurological consultation; (2) failing to document the medical records with legible entries of vital signs, examination and significant changes or response to treatments; (3) failing to order appropriate tests and medical investigation of symptoms; (4) failing to appropriately prescribe medications; and (5) failing to effectively communicate with D.D. about D.D.'s condition, treatment plan, and prescriptions. Complainant also alleged that respondent failed to keep adequate and accurate medical records for services rendered to D.D.

3. Respondent timely filed a Notice of Defense, pursuant to Government Code section 11506. The matter was set for an evidentiary hearing before an Administrative Law Judge of the Office of Administrative Hearings, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500 et seq.

Respondent's Background

4. In 1974, respondent completed his medical degree at the University of Iowa, College of Medicine. Thereafter he completed an internship at United Hospitals in St. Paul Minnesota. In 1975, he was licensed by the Board. In 1978, respondent completed a three-year residency in neurology at the University of California, Davis (UC Davis). In 1981, he obtained his board certification by the American Academy of Neurology and Psychiatry.

5. In a prior disciplinary action entitled, "In the Matter of the Accusation against Richard Neill Sauer, M.D." before the Medical Board of California, OAH No. 2017040877, respondent's certificate was revoked, the revocation stayed, and respondent was placed on Board probation for five years, subject to terms and conditions. The Board adopted the administrative law judge's proposed decision, which became effective on May 18, 2018. The allegations in the case included respondent's repeated acts of negligence in his treatment of two patients for migraines, failing to document and take vital signs, and ordering an unnecessary EEG study.

Board Investigation

6. On or about February 8, 2017, the Board received an online written complaint from D.D.'s caregiver, Meghan Maloney, who, at the time, was a recent registered nursing graduate. The complaint related to respondent's diagnosis and treatment of D.D.'s loss of motor skills, difficulty swallowing, difficulty speaking, and tremors. The complaint stated, in part:

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[1] The patient is identified by initials to protect the patient's privacy.

> I went with [D.D] to see [respondent] and was absolutely sickened by his demeanor and lack of empathy or concern for [D.D.]. He had a pleasant smile but never asked [D.D.] any questions or bothered to look at [D.D.] when [D.D.] was speaking.
>
> [D.D.'s] primary doctor told [D.D.] that she suspects MS[2] . . . Sadly, [respondent] laughed at [D.D.] saying no you don't have MS. But he didn't even ask her if things had changed or how she was since last visit!
>
> [¶] . . . [¶]
>
> He told [D.D.] the reason for [D.D.'s] new tremors was likely due to being in so much pain it was being expressed as a tremor. When I questioned his logic, asking for an explanation, he wasn't able to give me an answer that made sense and wrote a prescription for another medication without any info or explanation of how it would work or why he chose it.

7. On March 17, 2017, Michel Torres, a Special Investigator for the Department of Investigation, Health Quality Investigation Unit, was assigned to investigate the complaint. Investigator Torres issued an Investigation Report regarding his investigation of respondent. Investigator Torres testified at hearing. During the course of his investigation, Investigator Torres learned that Ms. Maloney had concerns about the care D.D. received from respondent on February 8, 2017, in that he did not address D.D.'s symptoms and prescribed D.D. medication that D.D. did not need. Ms. Maloney made attempts to contact respondent but did not receive a phone call back. Investigator Torres interviewed Ms. Maloney and D.D. He interviewed respondent and obtained his patient records for D.D.

8. On December 12, 2017, Investigator Torres sent a letter, draft report, a transcript of respondent's interview and the D.D.'s medical records to Board expert reviewer For Shing Lui, M.D., who is board-certified in Neurology. On December 18, 2017, Dr. Lui issued a report in which he opined that respondent's treatment of patient D.D. departed from the standard of care.

Respondent's Treatment of Patient D.D.

9. D.D. is 48 years old. At the time D.D. was seen by respondent, D.D. was 46 years old. Prior to seeing respondent, D.D. had been treated regularly by Marina Kamyshin, Physician Assistant (PA), at the Sacramento Family Medical Clinic. D.D. had a complicated medical history of hypertension, chronic pain, fibromyalgia, depression, obesity,

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[2] Multiple sclerosis.

cholelithiasis[3], and hepatosplenomegaly[4]. D.D. had a history of seizures during childhood and was treated with phenobarbital until age 13. D.D.'s seizures reoccurred in 2007. The seizures were described in the medical records as "inconsistent" and "not stereotyped." D.D. had an inconsistent history of any impairment of consciousness. D.D. experienced intermittent body spasms with full awareness. D.D. was sent to the emergency department at Mercy San Juan Medical Center with one of these spells.

10. D.D. is a chronic cigarette smoker and used methamphetamine. In 2012, D.D. attempted suicide by taking Ativan and methamphetamine. D.D. is unemployed, and has a caregiver 30 hours per week. Prior to being seen by respondent, D.D.'s medications included Atenolol, Losartan, Oxybutynin, Gabapentin, Cymbalta, Ibuprofen, Norco (as needed), Comapazine (as needed), and Zofran (as needed).

11. D.D.'s primary care provider, PA Kamyshin, referred D.D. to respondent. Respondent first saw D.D. on November 17, 2016[5], with follow-up appointments on December 15, 2016, February 7, 2017, and March 6, 2017. Respondent provided a typewritten report to PA Kamyshin concerning his initial evaluation of D.D., describing that D.D. presented with bothersome head and upper extremity tremor starting in 2011. D.D. also had a spell of tonic-clonic[6] activity in October 2016, with probable loss of consciousness during the spell. Examination was normal except mild intention of tremor of D.D.'s upper extremities. Respondent's impression was the following:

a. This patient's tremor appears to be a benign essential tremor. The patient is moderately bothered with this now.

b. The patient's tonic-clonic spell may be a seizure or have another etiology.

Respondent recommended further evaluation with an electroencephalogram (EEG) and ultrasonography, also referred to as transcranial ultrasound. Respondent also prescribed Keppra 500 milligrams (mg) and Mysoline 50 mg twice a day.

12. On December 7, 2016, respondent performed the transcranial Doppler ultrasound and EEG tests on D.D. Respondent reported the results of both tests as normal.

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[3] Gallstones.

[4] Enlarged liver and spleen.

[5] The First Amended Accusation identified the first visit date as November 7, 2016. However, respondent's typewritten report indicates that the first visit took place on November 17, 2016, which was confirmed by respondent and complainant's expert at hearing.

[6] Grand-mal seizure.

13. On December 15, 2016[7], respondent saw D.D. for a follow-up appointment. Respondent's handwritten notes of this visit were illegible. Respondent provided a transcription of his notes to Investigator Torres, wherein D.D. complainted of "twitching." Respondent noted a history of childhood seizures, and noted a normal examination. Respondent's impression was that some of the reported symptoms were "pseudoseizures." He continued D.D. on Keppra 500 mg twice a day. The record is unclear whether respondent also continued D.D. on Mysoline at the same dose, however, in D.D.'s follow-up appointments, respondent continued D.D. on Keppra and Mysoline at the same doses.

14. D.D. returned to respondent for a follow-up appointment on February 7, 2017. Respondent's handwritten clinical notes were illegible. Respondent told Investigator Torres during his interview that D.D. complained of the same symptoms as in previous visits, and that the D.D. spoke in whispers with intermittent normal voice. D.D.'s speech pattern had been abnormal since 2007. D.D.'s examination was unremarkable. Respondent continued D.D. on Keppra and Mysoline at the same doses.

15. D.D. returned to respondent for a follow-up appointment on March 6, 2017. Respondent's handwritten clinical notes were illegible. Based on respondent's transcription of his notes and his interview with Investigator Torres, D.D. complained of seizures, with one that occurred the previous day. D.D. spoke with a lisp, which respondent noted had been present since age five. Respondent increased the Keppra dosage to 500 mg, two tablets, twice a day. Mysoline was continued at the same dose. Respondent scheduled a repeat EEG and a return visit in six weeks. The EEG was performed on March 13, 2017, and reported by respondent as normal. D.D. also had magnetic resonance imaging (MRI) performed on April 1, 2017, which was reported as "artefactual."[8] D.D. failed to show up to her appointments with respondent on April 17, 2017, and May 2, 2017. Ms. Maloney, who was with D.D. during her appointments with respondent, filed her complaint with the Board on February 8, 2018.

Complainant's Expert

16. For Shing Lui, M.D., is Board-certified in neurology and the subspecialty of vascular neurology. Dr. Lui has been a Fellow of the American Academy of Neurology since 2017. In 1978, Dr. Lui graduated from the University of Hong Kong Medical School as the top graduate in his class. Following his residency in internal medicine, Dr. Lui went to England to become a Fellow in Clinical Neurology at the Regional Neurological Center. He returned to Hong Kong in 1984, as the medical officer at Queen Elizabeth Hospital, then

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[7] The First Amended Accusation indicates the follow-up visit took place on December 1, 2016. However, respondent's notes and complainant's expert confirmed that the follow-up visit occurred on December 15, 2016.

[8] "Artefactual" means referring to an inaccurate finding, deviation, or alteration of electronic readout or morphology due to some form of systemic error. (https://medical-dictionary.thefreedictionary.com/artefactual.)

worked in private practice as a neurologist and internist. Dr. Lui came to the United States, and in 1995, he became a resident in Neurology at UC Davis. He was Chief Resident at UC Davis in 1998. He thereafter served as a clinical professor at UC Davis from 1999 to 2014. He was Chief of Neurology Services at the Kaiser Permanente Medical Group in Sacramento and Roseville from 2004 to 2007.

Dr. Lui has served as a medical expert for the Board since September 2016. He currently serves as the Vice Chair of Clinical Sciences at California Northstate University College of Medicine.

17. Following a December 12, 2017 referral from Investigator Torres, Dr. Lui authored a report dated December 18, 2017, concerning his evaluation of respondent's conduct related to the treatment of D.D. In the report, Dr. Lui listed the documents he reviewed to reach his opinions and conclusions. Dr. Lui reviewed Investigator Torres's report, Ms. Maloney's complaint to the Board, the certified medical records of D.D., and a transcript and voice recording of respondent's interview with Investigator Torres. Dr. Lui testified at hearing consistent with the contents of his report. Dr. Lui opined that respondent's treatment of D.D. departed from the standard of care, which he defined as what a reasonable neurologist would do in a similar circumstance. Dr. Lui further explained that a simple departure from the standard of care means "any deviation," and an extreme departure from the standard of care means "reckless disregard or gross negligence."

INITIAL NEUROLOGY CONSULTATION

18. Dr. Lui opined that the standard of care for a neurologist's first consultation requires a detailed and comprehensive history of present illness, including relevant positives and negatives to help define the diagnosis and differential diagnoses. The elements of a complete history include: past medical history; medications; allergies; family history; social history; and review of systems. There should be at least a focused physical examination with vital signs documented. The assessment and plan should include a list of diagnoses or differential diagnoses with discussions about the more likely diagnoses followed by tests to help differentiate the diagnoses and recommend a treatment plan.

19. Dr. Lui reviewed respondent's typewritten report dated November 17, 2016, addressed to PA Kamyshin. Respondent's report stated that the initial consultation with D.D. occurred on November 17, 2016. Respondent listed two symptoms that D.D. complained of without providing details. Dr. Lui found no past medical history, history of allergies, an inadequate social history lacking alcohol and drug use, and no review of systems. There were no vital signs noted in D.D.'s examination except a blood pressure reading. Dr. Lui opined that respondent's description of D.D.'s history, and respondent's physical examination were "grossly inadequate." Moreover, respondent did not obtain any details about D.D.'s childhood seizures and treatment, yet diagnosed D.D with possible seizures and benign essential tremor. Dr. Lui concluded that respondent's first visit with D.D. was a simple departure from the standard of care.

FAILURE TO DOCUMENT MEDICAL RECORD WITH LEGIBLE ENTRIES OF VITAL SIGNS, EXAMINATION, AND SIGNIFICANT CHANGES

20. Dr. Lui opined that the standard of care for any physician is to take a complete or focused history and physical examination with truthful, accurate, and legible documentation in the patient's chart. Vital signs are an important part of the physical examination.

21. Dr. Lui reviewed respondent's notes in D.D.'s chart. The notes were handwritten, extremely brief, and illegible. Dr. Lui opined that respondent's documentation lacked any description of significant changes in D.D.'s existing problems and response to treatment. No vital signs were documented in any return visit after the initial consultation. Neither Dr. Lui nor any other physician would be able to rely on respondent's handwritten notes because they were illegible. Dr. Lui concluded that respondent's chart documentation in D.D.'s medical record was a simple departure from the standard of care.

FAILURE TO ORDER APPROPRIATE TESTS AND MEDICAL INVESTIGATION OF SYMPTOMS

22. Dr. Lui opined that the standard of care in clinical practice by any physician for requesting or ordering tests or investigations is to define the indication of the test as well as cost consideration under the circumstances.

23. Dr. Lui further opined that D.D. presented with "clinical seizures or pseudoseizures" and tremor, and that it would be important for respondent to obtain a history from D.D. to get details of the "spells" and the factors that may aggravate or alleviate D.D.'s symptoms of tremor. Logical lab studies would include a complete metabolic panel, thyroid function, EEG, and MRI. A metabolic panel would be informative due to D.D.'s enlarged liver and spleen. Thyroid function studies would also be important because the thyroid could be the cause of D.D.'s tremor. Respondent ordered an EEG, and he determined that the results were normal. Respondent did not order or obtain recent results of the thyroid or metabolic panel tests.

24. Dr. Lui testified that a transcranial Doppler test is indicated for the following reasons: (1) sickle cell disease where a follow-up is needed to determine the patient's need for a blood transfusion; (2) subarachnoid hemorrhage vasospasm[9]; and (3) determining velocity of blood flow in the intracranial vessels. There was nothing in D.D.'s history to indicate a stroke. There was "absolutely NO indication for the transcranial Doppler testing" for D.D. (Capital letters in original.) Dr. Lui concluded that the transcranial Doppler test requested by respondent was a simple departure from the standard of care.

[9] Bleeding in the space between the brain and the tissue covering the brain. (https://emedicine.medscape.com/article/1164341-overview.)

FAILURE TO APPROPRIATELY PRESCRIBE MEDICATIONS

25. Dr. Lui opined that the standard of care in prescribing any medication by a physician requires the physician to know the patient's past medical history, including renal and liver functions. Those functions provide information on whether any dose adjustment is necessary. In addition, allergy and social history, especially use of alcohol and street drugs, may affect the choice of medications prescribed to the patient. Obtaining a detailed history of the patient's medications is especially important because of drug interactions. It is only after obtaining the patient's histories that the best medication specific to the patient may then be prescribed.

26. Dr. Lui determined that respondent obtained very limited medical history of D.D. Respondent also needed to obtain vital signs. D.D. used methamphetamine, which could have increased her blood pressure and heart rate. D.D. was taking Gabapentin for seizures and tremors. Gabapentin may increase body weight. Given that D.D. was morbidly obese, considered as having a body max index (BMI) over 40, respondent would have needed to continue discussing with D.D. whether to discontinue Gabapentin. In a morbidly obese individual such as D.D., continued use of Gabapentin would have affected D.D.'s everyday activities, and contributed to sleep apnea, right side heart failure, metabolic syndrome, and liver and spleen enlargement.

27. D.D. was also taking Mysoline, known as a "beta-blocker," which may have helped her tremors. Instead of adding a new medication with different side effects, Dr. Lui opined that respondent should have considered adjusting the dose of her existing medications before switching to a new medication. He stated, "when we start a patient on a new medication, we need to explain very clearly the reason for the use, side effects, and it relevance on the effects of daily living."

Respondent knew that D.D. was taking Cymbalta[10] for fibromyalgia. Despite being contraindicated for depression, respondent prescribed Keppra for D.D.'s seizures, which was troubling for Dr. Lui, and "would not have been a good choice in the presence of depression." Dr. Lui opined that 15 percent of patients taking Keppra will experience the side effect of depression. Dr. Lui further opined that prescribing Keppra "was especially risky" given that D.D. attempted suicide in 2012. Moreover, respondent increased the dose of Keppra when he suspected more pseudoseizures. Dr. Lui conceded that Keppra is commonly used, and he gave respondent "the benefit of the doubt" in this regard. However, given D.D.'s depression and suicidal history, Dr. Lui concluded that respondent's choice of prescription medication, Keppra, was a simple departure from the standard of care.

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[10] Duloxetine is the generic name for Cymbalta. It is used to treat depression and anxiety. In addition, duloxetine is used to help relieve nerve pain (peripheral neuropathy) in people with fibromyalgia and other medical conditions. (https://www.webmd.com/drugs/2/drug-91491/cymbalta-oral/details.)

FAILURE TO EFFECTIVELY COMMUNICATE WITH PATIENT D.D.

28. Dr. Lui opined that the standard of care for a physician to communicate with a patient "is to always try to communicate well with the patient and show empathy." Diagnoses, treatment plans, medications prescribed and their indications, side effects, and drug interactions, must be clearly conveyed to the patient.

29. Dr. Lui found no documentation in D.D.'s chart that respondent explained to D.D. and Ms. Maloney any details about D.D.'s diagnoses, or the risks and benefits of medication prescribed to D.D. Dr. Lui opined that neither D.D. nor Ms. Maloney would have filled the Keppra prescription had they known of Keppra's side effects of depression, given D.D.'s history. Dr. Lui noted that inadequate communication and lack of empathy by respondent was also the main complaint filed by Ms. Maloney. D.D. called respondent the day after her March 13, 2017 EEG appointment, seeking clarification on how often she was to take a particular prescribed medication, demonstrating respondent's failure to effectively communicate with D.D. on how to take the medication. Dr. Lui did not see from respondent's documentation "any real communication." Dr. Lui testified that "MS was not discussed. I would expect respondent would document that MS was brought up by the provider and referring PA, and that respondent would document that [MS] was not likely." Dr. Lui concluded that respondent's failure to effectively communicate was a simple departure from the standard of care.

Respondent's Testimony

30. Respondent acknowledged that his handwritten notes regarding D.D. were difficult to read. However, he claimed that he was able read his own notes, as was his staff. Respondent later conceded, "there is always room for improvement" concerning his medical record documentation. When asked about a note written by one of his staff, which was also difficult to read, respondent snidely remarked that the Board should "go after her too" for poor penmanship. Respondent has a transcriber, and he will "type more and write less" in the future. He referred to his handwritten notes as "secret handwriting" which enables him at the end of the day to dictate a specific note to the referring doctor. Respondent described himself as the "pawn of the referring doctor," meaning that the referring doctor is less concerned with his notes than the ongoing treatment plan for the patient. He asserted that referring physicians have been happy with his typewritten reports.

31. Respondent also asserted that he performs a thorough and focused examination of his patients, which includes history taking. He relies on the primary care provider to provide the vital signs. Respondent did not take D.D.'s temperature or weight, explaining that this information was not pertinent to the referral. He "rarely checks" the blood pressure of patients. He noted D.D.'s blood pressure during his initial consultation, but he did not know who took D.D.'s blood pressure, stating that either the patient told him, it was on another record, or his staff took D.D.'s blood pressure. He believed it a "ludicrous

suggestion" to document oxygen saturation,[11] which should be done by a pulmonologist, not him. In his experience, no one has "jotted that down" as a vital sign. He asserted that every patient that comes to his practice has already had their vital signs taken, and therefore the vital signs need not be a part of his documentation. He only focuses on what is asked of him. Respondent claimed that he discussed D.D.'s vital signs with PA Kamyshin, but there is no documentation of that discussion.

32. Respondent has performed transcranial Doppler tests since the technology was invented. He performs four to six tests per month. He stated that the test is non-invasive, not painful, and is a tenth of the cost of other technologies. The transcranial Doppler is helpful in providing information about vasospasms, blood flow, and seizure activity. Respondent ordered a transcranial Doppler test for D.D. because D.D.'s "tremor history was confusing," D.D. was a smoker that potentially put her at risk for stroke, and the test would have provided information on blood vessel abnormalities, blood flow problems, stroke detection, and vascular supply to neurons, known as neurovascular coupling.

33. Respondent did not order a metabolic panel or thyroid function test for D.D., but would have done so in a "brand new patient with no testing or blood workup." If D.D. presented with a suspicious condition of a metabolic process or thyroid abnormality, or if D.D. had clinical signs of low or high thyroid hormone levels, he would have ordered the tests.

34. Respondent has prescribed Keppra to "thousands of people." It is an anti-convulsant used in the treatment of seizures. Respondent chose Keppra for D.D. for two reasons: (1) Keppra prevented D.D. from dying from a seizure; and (2) Keppra would "stop or diminish the spells [D.D.] was describing." Respondent also chose Keppra for D.D. because it would not interact with the Gabapentin D.D. was taking. In his experience, respondent believed that Keppra and Gabapentin were a good combination. He also chose Keppra because over 50 percent of people actually need more than one anti-convulsant. Respondent asserted that very few, out of the thousands of his patients, have had a side effect from Keppra, and none have experienced depression or suicidal ideation. Respondent had no documentation that he communicated the negative effects of Keppra to D.D., and admitted that he did not inquire about D.D.'s condition after he prescribed Keppra.

35. Respondent did not address his lack of communication with D.D. about D.D.'s condition, treatment plan, and prescriptions. Respondent testified that D.D. stopped seeing him because there was a "personality conflict" between himself and Ms. Maloney.

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[11] Oxygen saturation is typically measured using a pulse oximeter. The patient's finger is inserted into spring-loaded clip which is attached to a sensor that provides a digital readout of the patient's oxygen saturation level. (https://www.healthline.com/health/pulse-oximetry.)

Discussion of Allegations

INITIAL NEUROLOGY CONSULTATION

36. Complainant alleged that respondent failed to perform an adequate initial neurological consultation on D.D., including failing to obtain detailed symptoms, perform a history and a physical, obtain significant social, allergy and medical history, and history of childhood seizures to reach a proper diagnosis and treatment plan. Complainant alleged that respondent's conduct constituted a repeated act of negligence, failure to maintain adequate and accurate records and general unprofessional conduct.

37. Dr. Lui persuasively opined that the standard of care requires that the treating neurologist's first consultation requires documentation of a detailed and comprehensive patient history, along with a focused physical examination with vital signs documented. This information is necessary to establish a list of diagnoses or differential diagnoses and a treatment plan. Dr. Lui opined that it is a simple departure from the standard of care to fail to document the patient's history and physical examination. Respondent's documentation in this regard was "grossly inadequate."

38. Respondent believed that he performed a thorough and focused examination, and provided an adequate history during his initial neurological consultation with D.D. Describing himself as the "pawn of the referring doctor," respondent asserted that he relies on the primary caregiver to obtain all of the detailed information that Dr. Lui set forth as the standard of care. Respondent provided no conflicting expert opinion on the standard of care.

39. The evidence established that respondent failed to document detailed symptoms, a thorough history and physical examination with vital signs for D.D. Respondent's assertion that referring physicians are happy with his reports is irrelevant.

40. Complainant established by clear and convincing evidence that respondent failed to perform an adequate initial neurological consultation on D.D. His conduct constituted a simple departure from the standard of care, failure to maintain adequate and accurate records and general unprofessional conduct.

LEGIBLE RECORDS

41. Complainant alleged that respondent failed to document the medical record adequately with legible records of vital signs, examination, and significant changes or response to treatments. Complainant further alleged that respondent's conduct constituted repeated acts of negligence, failure to maintain adequate and accurate records, and general unprofessional conduct.

42. Dr. Lui persuasively opined that the standard of care for charting is to legibly and accurately document the relevant medical information, including the vital signs of the patient. Respondent provided no conflicting expert testimony on the standard of care.

43. Respondent acknowledged his illegible notes regarding D.D. He explained that he and his staff could understand his writing, which he intended to transcribe later. However, even when transcribed, the content of the records was lacking in vital signs, and information concerning symptoms and response to treatment.

44. Complainant established by clear and convincing evidence that respondent failed to legibly and accurately document relevant medical information, including vital signs of D.D. His conduct constituted a simple departure from the standard of care, failure to maintain adequate and accurate records and general unprofessional conduct.

ORDERING APPROPRIATE TESTS AND MEDICAL INVESTIGATION OF SYMPTOMS

45. Complainant alleged that respondent failed to order appropriate tests and medical investigation of symptoms, by ordering unnecessary tests, such as the transcranial Doppler test, and failing to obtain necessary tests such as a metabolic panel and thyroid function tests. Complainant alleged that respondent's failures constituted repeated acts of negligence, failure to maintain adequate and accurate medical records, and general unprofessional conduct.

46. Dr. Lui persuasively opined that the standard of care in ordering tests or investigations is to define the indication, and to consider the cost. Dr. Lui further persuasively opined that there was no indication for ordering the transcranial Doppler test for D.D. Respondent provided no conflicting expert opinion on the standard of care. Respondent's testimony that he ordered the transcranial Doppler test because it would have provided information on stroke detection or blood vessel abnormalities was less persuasive, because respondent did not document any differential diagnoses that would have justified the test. Dr. Lui is Board-certified in neurology and in the subspecialty of vascular neurology, which specifically addresses blood flow in the brain. His opinion with respect to respondent unnecessarily ordering the transcranial Doppler test for D.D. is given greater weight. Dr. Lui did not find any departures from the standard of care with respect to respondent failing to obtain necessary tests such as the metabolic panel and thyroid function tests.

47. The evidence did not establish that respondent violated the standard of care by failing to obtain necessary tests such as the metabolic panel and thyroid function tests. Complainant established by clear and convincing evidence that respondent's conduct in ordering the transcranial Doppler test, without medical indications, constituted a simple departure from the standard of care, failure to maintain adequate and accurate records and general unprofessional conduct.

PRESCRIBING APPROPRIATE MEDICATIONS

48. Complainant alleged that respondent failed to appropriately prescribe medications, including prescribing Keppra in the presence of psychiatric and suicide history, and adding new medications without reference to existing prescriptions. Complainant

alleged that respondent's conduct constituted a repeated act of negligence, failure to maintain adequate and accurate records and general unprofessional conduct.

49. Dr. Lui persuasively opined that the standard of care in prescribing any medication requires the physician to know the patient's past medical history, including renal and liver functions, as that information may require dosage adjustments. The standard of care also requires the physician to obtain a detailed history of the patient's medications as there may be drug interactions. Respondent provided no conflicting expert testimony on the standard of care.

50. Respondent's prescribing of Keppra to D.D. is the most serious issue in this case. Despite respondent's testimony that he prescribes Keppra to "thousands," and none of his patients have experienced depression or suicidal ideation, he provided no appropriate consideration of D.D.'s past history. If he did, it was not documented. The purpose of obtaining and considering the patient's history is to limit the risk of potential drug interactions and side effects. Respondent did not inquire about D.D.'s condition after the last time he saw her, and would have no way of knowing whether D.D. experienced any negative effects while taking Keppra.

51. The evidence established that respondent prescribed Keppra to a D.D., a patient with a history of depression and suicide. Complainant established by clear and convincing evidence that respondent's choice of Keppra was a simple departure from the standard of care, failure to maintain adequate and accurate medical records and general unprofessional conduct.

EFFECTIVE COMMUNICATION WITH PATIENT D.D.

52. Complainant alleged that respondent failed to communicate with D.D. about D.D.'s condition, treatment plan, and prescriptions. Complainant alleged that respondent's conduct constituted a repeated act of negligence, failure to maintain adequate and accurate medical records and general unprofessional conduct.

53. Dr. Lui persuasively opined that the standard of care in effectively communicating with a patient is to show empathy, and to clearly convey to the patient diagnoses, treatment plans, prescribed medications and their indications, side effects and drug interactions. Respondent provided no conflicting expert testimony on the standard of care.

54. Respondent did not acknowledge that he failed to effectively communicate with D.D. regarding her treatment, or that he lacked empathy. He defended his illegible handwriting by asserting that he and his staff could read his notes, and referred to his notes as "secret handwriting." However, any reviewing doctor or D.D. would not be able to read or understand such notes, particularly if there are no transcribed notes in the patient's medical record. He did not convey to D.D. the risks to taking Keppra. He did not follow up with D.D. to inquire as to her condition when she stopped seeing him. He appeared defensive at

hearing in having to account for his medical decision-making. Respondent provided no credible or persuasive testimony to demonstrate that he met the standard of care.

55. Complainant established by clear and convincing evidence that respondent's failure to communicate with D.D. about D.D.'s condition, treatment plan, and prescriptions, was a simple departure from the standard of care, a failure to maintain adequate and accurate medical records and general unprofessional conduct.

Rehabilitation Evidence

56. Respondent submitted five character reference letters which were received in evidence and considered to the extent permitted by Government Code section 11513, subdivision (d).[12]

a. Ingeborg Henderson, Ph.D., wrote in an email sent to respondent on January 9, 2019, that she has been treated by respondent since 2007 for chronic pain. Respondent suggested a course of treatment that restored Ms. Henderson's quality of life. Ms. Henderson was "profoundly impressed" with respondent's care, as well as respondent's willingness to "always listen" to Ms. Henderson's concerns, and to answer all of her questions. Ms. Henderson described respondent as a credit to his profession.

b. Sayed Hussain, M.D., wrote in his signed letter of January 7, 2019, that he has known respondent for decades, has referred patients "back and forth" over the years, and characterized respondent as an excellent physician. Dr. Hussain is aware of the Board's allegations in this case. Dr. Hussain's opinion is that respondent is "an honest, caring and competent physician, and certainly very professional." The allegations against respondent do not alter Dr. Hussain's opinion of respondent.

c. Raymond Mikelionis, M.D., wrote in his undated, signed letter, that he has known respondent for 40 years, and has worked with respondent in hospitals and a clinic. Dr. Mikelionis described respondent as a "mainstay" at the local hospital who has "excellent results" as a general neurologist. Dr. Mikelionis especially appreciates respondent's "expertise in treating seizures." Dr. Mikelionis aware of the Board's allegations in this case, but his

[12] Government Code section 11513, subdivision (d), provides, in pertinent part, that "[h]earsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions."

opinion of respondent as "very professional, honest, caring and competent" has not changed.

d. Algerd Mostavicius wrote in his signed letter of January 7, 2019, that he was a licensed physician in California from 1967 to 2017. He voluntarily surrendered his license (no payment of fees) and was in good standing with the Board. Mr. Mostavicius's wife, Barbara, was also an M.D. who surrendered her license in 2017 due to Alzheimer's Disease. Both are being treated by respondent. Both are aware of the Board's allegations, and are of the opinion that respondent is an "honest, well-trained, caring and very competent physician."

e. David S. Gould wrote in his signed and dated letter of January 7, 2019, that he has known respondent for many years, and "his care is of the highest standard." Mr. Gould is aware of the Board's allegations, "which in part includes an argument over which seizure medicine ought to be used." Despite the Board's allegations, Mr. Gould's opinion of respondent is not altered. He described respondent as an "honest, caring and competent physician, and certainly very professional."

57. The authors of the character reference letters were either physicians or respondent's patients. Mr. Gould is a good friend. Most of the authors had knowledge of the Board's allegations, but their opinion of respondent as a competent and compassionate medical professional did not change. Despite their knowledge of the Board's allegations, none of the authors provided any insight into respondent's efforts at rehabilitation despite the charges. (See, *Seide v. Committee of Bar Examiners of the State Bar of California* (1989) 49 Cal.3d 933, 940 ["If the character witnesses were not aware of the extent and seriousness of the petitioner's criminal activities, their evaluations of his character carry less weight."].) While there are no criminal activities at issue in this case, respondent's failure to adequately document D.D.'s symptoms, treatment, medical history, medications history, social history, and his failure to effectively communicate D.D.'s condition, treatment plan and prescriptions, were not addressed by any of the authors. Because the authors do not discuss knowledge of respondent's conduct, they are of limited value in assessing rehabilitation.

Appropriate Discipline

58. Complainant established by clear and convincing evidence the allegations contained in the First Amended Accusation. Additionally, complainant established that respondent engaged in multiple simple departures from the standard of care, including failing to conduct an adequate initial consultation, documenting D.D.'s medical record with illegible notes, ordering a transcranial Doppler test without indication, prescribing inappropriate medication for the D.D., and failing to effectively communicate with D.D.

59. Most concerning is respondent's failure to acknowledge the serious nature of his multiple failures in treating D.D. He failed to maintain adequate and accurate records. His handwritten notes were illegible. He failed to document detailed information on D.D.'s medical history in order to reach a proper diagnosis and treatment plan. He did not convey medication risks.

60. Respondent failed to understand the seriousness of his illegible handwritten notes. A member of his staff also had poor handwriting which was difficult to read, and respondent snidely remarked that the Board should "go after her too" for poor penmanship. Respondent's hubris raises serious questions about his ability to examine his own professional conduct, take ownership of his actions, improve his practices as a medical practitioner, be open to accept challenges or suggestions by other medical practitioners, and demonstrate compassion towards patients. Respondent's preference of his own medical judgment over that of others poses a danger to his patients. At hearing, he demonstrated sarcasm and lack of respect for the discipline process, and the important role that the Board holds in protecting the public.

61. Respondent has been licensed to practice medicine in California since 1975. The Board imposed discipline in a prior Medical Board Case, OAH No. 2017040877. The allegations in the prior Board case involved, in part, respondent's treatment for migraines using Botox, his failure to document and take vital signs, and ordering of an unnecessary EEG test. Due to the severity of respondent's conduct and violations in that case, the Board needed assurances that respondent is safe to practice. The Board's Disciplinary Guidelines were considered, and discipline was imposed without deviation from the guidelines. The Board imposed a five-year disciplinary term, and required practice monitoring and a medical record keeping and ethics course, and a no solo practice term.

62. Here, D.D. was being treated for tremors and seizure, and the allegations highlighted the deficiencies in respondent's overall care and treatment, not just a specific subspecialty of neurology. This case implicated a much larger question of respondent's general fitness to practice. The protection of the public is the Board's highest priority. In determining appropriate disciplinary action and in exercising disciplinary authority the Board shall, whenever possible, "take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence." (Bus. & Prof. Code, § 2229, subd. (b).)

63. The Board's Disciplinary Guidelines provide the recommended minimum and maximum penalties for Business and Professions Code violations. For violation of Business and Professions Code sections 2234 (general unprofessional conduct), 2234, subdivision (c), (repeated negligent acts), and 2266 (failure to maintain adequate records), the minimum penalty[13] is stayed revocation and five years of probation with conditions designed to protect

[13] The Board's Guidelines note that "in cases charging repeated negligent acts with one patient, a public reprimand may, in appropriate circumstances, be ordered."

the public. The maximum penalty is revocation. There is no basis here to deviate from the Disciplinary Guidelines.

64. Based on the totality of the evidence, the public protection would be served by imposing a five-year term of probation, with terms and conditions designed to protect the public. The five-year term of probation shall run concurrently with respondent's five-year term of probation in OAH Case No. 2017040877. Consistent with the conditions of probation in that case, respondent is prohibited from engaging in a solo practice and is required to obtain a practice monitor who will ensure that his practices are within the standards of practice of medicine. He is directed to complete a professionalism program and medical record keeping course to ensure that he understands his ethical obligations and his duty to maintain accurate and adequate records. Lastly, an additional term of probation, not required in his previous Medical Board case, will be required: Respondent shall complete a Clinical Competence Assessment Program as a condition precedent to his continuing practice. Completion of the assessment program will give the Board adequate assurances that the issues raised in the present case have been addressed, respondent's general fitness to practice is sound, and public protection is served.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

Burden and Standard of Proof

2. Complainant has the burden of proving each of the grounds for discipline alleged in the Accusation, and must do so by clear and convincing evidence. (See, *Ettinger v. Board of* Medical *Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence is evidence that leaves no substantial doubt and is sufficiently strong to command the unhesitating assent of every reasonable mind. (See, *In re Marriage of Weaver* (1990) 224 Cal.App.3d 478.)

Applicable Law

3. Business and Professions Code section 2227 provides in pertinent part that a licensee that has been found "guilty" of violations of the Medical Practices Act, shall:

> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

4. Business and Professions Code section 2234 provides that the Board shall take action against any licensee found to have engaged in unprofessional conduct, which includes but is not limited to the following:

[¶] . . . [¶]

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1) including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

5. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care applicable in a medical professional must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal. App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.) The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052. Simple negligence is merely a departure from the standard of care.

6. Business and Professions Code section 2266 provides that failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

Causes for Discipline

7. Complainant established by clear and convincing evidence that respondent's treatment of D.D. constituted repeated acts of negligence, as set forth in Factual Findings 18 through 29, and 36 through 55. Therefore, cause was established to impose discipline on respondent's certificate pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c).

8. Complainant established by clear and convincing evidence that respondent failed to maintain adequate and accurate records related to his treatment of D.D. as set forth in Factual Findings 18 through 29, and 36 through 55. Therefore, cause exists to impose discipline on respondent's certificate pursuant to Business and Professions Code sections 2227 and 2234, as defined by section 2266.

Conclusion

9. The objective of an administrative proceeding relating to licensing is to protect the public. Such proceedings are not for the primary purpose of punishment. (See *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) When all the evidence is considered, respondent's certificate should be placed on probation for a period of five years, with appropriate terms and conditions set forth below, to protect the public. Respondent's five-year probation in this case shall run concurrent with his five-year probation imposed in a prior Medical Board case, OAH No. 2017040877.

ORDER

Physician's and Surgeon's Certificate A 29403 issued to respondent Richard Neill Sauer M.D. is REVOKED, pursuant to Legal Conclusions 7 and 8, but the revocation is STAYED, and respondent is placed on probation for five years, upon the following terms and conditions listed below. The five-year probationary period shall run concurrently with the five-year probationary period currently in effect pursuant to OAH No. 2017040877.

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval of educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the

Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours are in satisfaction of this condition.

2. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. Monitoring – Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine and whether respondent is practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior

approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

5. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the respondent's practice setting changes and the respondent is no longer practicing in a setting in compliance with this Decision, the respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

6. Notification

Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to

respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice: Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years. Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

13. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

14. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

17. Clinical Competence Assessment Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusations(s), and any other information that the Board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of three and no more than five days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendations(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

Respondent shall not practice medicine until respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

DATED: March 19, 2019

DocuSigned by:
Danette C. Brown
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **RICHARD NEILL SAUER, M.D.** **729 Sunrise Ave., #616** **Roseville, CA 95661** **Physician's and Surgeon's Certificate No. A 29403** Respondent.	Case No. 800-2017-030024 OAH No. 2018040456 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 28, 1975, the Medical Board issued Physician's and Surgeon's Certificate No. A 29403 to Richard Neill Sauer, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2020, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code), unless otherwise indicated.

4. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the

proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligence)

7. Respondent Richard Neill Sauer, M.D., is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he was repeatedly negligent in his care and treatment of Patient 1. The circumstances are as follows:

8. Patient 1 was a 46-year-old woman when she was first seen by Respondent. Her medical history is complex, including hypertension, chronic pain, fibromyalgia, depression, obesity, cholelithiasis, and hepatosplenomegaly. She had a history of seizures in childhood, but there is little reliable history of the nature of these childhood seizures. She was treated with phenobarbital until the age of 13. She did not have seizures as an adult until a recurrence in approximately 2007. The description of returned seizures is inconsistent, with varying reports as to whether she had any loss or impairment of consciousness. She complained of and was reported to have intermittent body spasms with full awareness. She was seen in the Emergency Room of San Juan Medical Center for one of these episodes.

9. Patient 1 is a chronic cigarette smoker and has a history of methamphetamine use. In 2012, she attempted suicide by taking Ativan and methamphetamine. She does not work, and has a caregiver for 30 hours per week. Before seeing Respondent, her medications included Atenolol,

Losartan, Oxybutynin, Gabapentin, Cymbalta, and Ibuprofen, with Norco, Compazine, and Zofran as needed.

10. Respondent is a Board-certified neurologist. Patient 1 was referred to Respondent by her primary care provider. Respondent first saw Patient 1 on or about November 7, 2016, and then followed up with him on or about December 15, 2016, February 7, 2017, and March 6, 2017. At the first appointment with Respondent, on or about November 7, 2016, Respondent prepared a report which he sent to Patient 1's primary care provider. Respondent's report indicated that Patient 1 presented with bothersome head and upper extremity tremor starting in 2011, and that she experienced a spell of tonic-clonic activity in October of 2016 with probable loss of consciousness. Respondent noted that the examination was essentially normal except for a mild intention tremor of the upper extremities. Respondent diagnosed a benign essential tremor and seizure or alternately, an etiology of the tonic-clonic spell. Respondent recommended an EEG, and a transcranial ultrasound and prescribed Keppra 500 mg twice daily and Mysoline 50 mg twice daily.

11. The transcranial doppler ultrasound and EEG were performed in Respondent's office on or about December 7, 2016, and were reported as normal. Patient 1 saw Respondent for follow up on or about December 1, 2016. Respondent's notes of this visit are illegible. Respondent provided a translation of his notes to Board investigators when he was interviewed, in which he relayed his notes as indicating that Patient 1 complained of twitching. Respondent further noted that Patient 1 had a history of childhood seizures, and recorded a normal examination. Respondent's impression was that some of the reported symptoms were pseudoseizures. He continued Patient 1 on Keppra 500 mg twice per day.

12. Patient 1 returned for follow up on or about February 7, 2017. Respondent's notes are again illegible, but based on his translation of the notes, he recorded that Patient 1 was speaking in whispers with intermittent normal voice. Her speech pattern had been abnormal since 2007. Her examination was unremarkable. She was continued on treatment with Keppra and Mysoline at the same dose.

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13. Respondent saw Patient 1 for the last time on or about March 6, 2017. Again, the illegible notes as translated by Respondent indicated that Patient 1 complained of seizures, having had one the previous day. She spoke with a lisp, which had been present since age five. The dose of Keppra was increased to 500 mg, two tablets twice daily, and the Mysoline was continued at the same dose. Respondent ordered a repeat EEG and return visit in six weeks. The EEG was performed on March 13, 2017 and Respondent reported it to be normal. Patient 1 also had an MRI performed on April 1, 2017, which was reported as artefactual. Patient failed to show up to her appointments on April 17, 2017 and May 2, 2017. Patient 1's caregiver, who was present for the appointments, complained that Respondent failed to address symptoms Patient 1 reported such as loss of motor abilities, random shocks, swallowing difficulties, and chronic pain.

14. Respondent was repeatedly negligent in his care and treatment of Patient 1 in that each of the following represents a separate departure from the standard of care:

(a) He failed to perform an adequate initial neurological consultation on Patient 1, including failing to obtain detailed symptoms, perform a history and physical, obtain significant social, allergy and medical history, and history of childhood seizures to reach a proper diagnosis and treatment plan;

(b) He failed to document the medical record adequately with legible records of vital signs, examination, and significant changes or response to treatments;

(c) He failed to order appropriate tests and medical investigation of symptoms, by ordering unnecessary tests, such as the transcranial doppler test and failing to obtain necessary tests such as metabolic panel and thyroid function tests;

(d) He failed to appropriately prescribe medications, including prescribing Keppra in the presence of psychiatric and suicide history, and adding new medications without reference to existing prescriptions; and

(e) He failed to effectively communicate with Patient 1 about her condition, treatment plan and prescriptions.

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SECOND CAUSE FOR DISCIPLINE

(Inadequate or Inaccurate Medical Records)

15. Respondent Richard Neill Sauer, M.D., is subject to disciplinary action under sections 2234 and 2266 by failing to maintain adequate and accurate records relating to the provision of services to Patient 1.

16. Paragraphs 7 through 14 are incorporated by reference as if fully set forth here.

17. As set forth in paragraphs 7 through 14 Respondent failed to maintain adequate and accurate records of his care and treatment of Patient 1, thus subjecting his license to disciplinary action.

DISCIPLINARY CONSIDERATIONS

18. To determine the degree of discipline, if any, to be imposed on Respondent Richard Neill Sauer, M.D., Complainant alleges that on or about May 25, 2018, in a prior disciplinary action entitled, "In the Matter of the Accusation Against Richard Neill Sauer, M.D." before the Medical Board of California, in Case No. 800-2014-002745, Respondent's license was revoked. However, the revocation was stayed and Respondent's Physician's and Surgeon's Certificate was placed on probation for a period of five years with certain terms and conditions. That decision is now final and is incorporated by reference as if fully set forth herein.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 29403, issued to Richard Neill Sauer, M.D.;

2. Revoking, suspending or denying approval of Richard Neill Sauer, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Richard Neill Sauer, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: January 23, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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